Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVN4295ADC	A. BUILDING _____ B. WING _____	01/05/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JAN JANDREAU II	5385 MADEIROS DRIVE SUN VALLEY, NV 89433

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
U 000	INITIAL COMMENTS Surveyor: 28384 This Statement of Deficiencies was generated as a result of the State Licensure survey conducted at your facility on January 5, 2010. The survey was conducted using Nevada Administrative Code (NAC) 449, Facilities For Care Of Adults During The Day, regulations adopted by the Nevada State Board of Health on June 23, 1986. The facility was licensed for 10 total day care clients. The census at the time of the survey was zero. No resident files were reviewed and one employee file was reviewed. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following regulatory deficiencies were identified:	U 000		
U 89 SS=F	449.4073 Files Concerning Employees A separate file must be maintained and kept current on each employee. The file must include the following: 5. All required health certificates. This Regulation is not met as evidenced by: Surveyor: 28384 Based on record review and interview on 1/05/10, the facility failed to maintain a current file on each employee (Employee #1 - missing evidence of physical examination, documentation of positive TB skin test and chest x-ray).	U 89		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVN4295ADC	A. BUILDING _____ B. WING _____	01/05/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JAN JANDREAU II	5385 MADEIROS DRIVE SUN VALLEY, NV 89433

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
U 89	Continued From page 1 Severity: 2 Scope: 3	U 89		
U155 SS=F	449.4079 Required Services The facility must: 6. Have at least one employee on the premises at all times who is trained to administer first aid and cardiopulmonary resuscitation. This Regulation is not met as evidenced by: Surveyor: 28384 Based on record review and interview on 1/05/10, the facility failed to have at least one employee on the premises at all times who is trained to administer first aid and cardiopulmonary resuscitation (Employee #1). Severity: 2 Scope: 3	U155		